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Monitoring the Impact of Managed Care on Mothers and Children in Seattle/King County

Prepared for:

Division of Community and Family Health
Washington State Department of Health

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Prepared by:

Healthy Policy Analysis Program
University of Washington
Seattle,Washington

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9 August 1994

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Appendix A: Key Informants and Pre-Implementation Survey

I. The Need for a Maternal and Child Health Monitoring System

A. Introduction and Overview of the Project

Washington State's health care system is undergoing a fundamental transformation. Before the end of the decade, all residents of the state will receive health care through managed care arrangements financed jointly by government, employers, and individuals. On October 1, 1993, more than 60,000 people living in King County began the transition into mandatory Medicaid managed care under the Healthy Options program. The Washington Legislature authorized this process in the spring of 1993 with passage of the Washington Health Services Act. Prior to this Act, however, managed care was already becoming the dominant method of health care organization and financing in the state. The implementation of Medicaid managed care has accelerated since 1989, when the Washington State Department of Social and Health Services began phasing in mandatory Medicaid managed care in successive Washington counties.

Seattle and King County, where 30 percent of the state's residents live, is the fifth Washington county to implement this program. All counties in the state are scheduled to have implemented mandatory Medicaid managed care by June 1994, at which point more than 250,000 individuals in Washington are expected to be enrolled.

Washington State's Medicaid agency, the Department of Social and Health Services Medical Assistance Administration (MAA), expects Medicaid managed care to address a host of problems associated with fee-for-service Medicaid programs, including:

- Limited access to care due to an insufficient number of providers accepting Medicaid patients;
- Rapidly rising caseloads among providers who take Medicaid clients;
- Inappropriate use of medical services, particularly through hospital emergency rooms;
- Providers' complaints of low reimbursement rates; and
- Rising costs.

Medicaid managed care is designed to increase access to care by enrolling more providers, to increase use of preventive services, and to encourage continuity of care.

Health policy makers began informal preparation for the shift to Medicaid managed care in Seattle/ King County more than a year before implementation began. Beginning in the fall of 1992, they met regularly to address such issues as preparing the local community for the shift and planning for data-gathering by participating health plans. At the same time, the Division of Parent and Child Health Services (PCHS) of the Washington State Department of Health (DOH) recognized the need to design a system to measure the impact of managed care on public health clients, providers, and systems and to collect a baseline set of health and system status indicators to measure the impact of managed care over time.

In December 1992, PCHS officials approached Health Systems Research, Inc. (HSR) to see if the firm could assist in developing this monitoring system. These officials had been informed that HSR had been awarded a three-year contract by the Maternal and Child Health Bureau (MCHB) of the U.S. Public Health Service to provide technical assistance to states as they develop comprehensive systems of primary health care for infants, children, and families. Under the contract, HSR was to provide 25 states with technical assistance over a three-year period. During the fall of 1992, 32 states submitted requests for technical assistance to HSR. The state of Washington was one of six states selected to receive technical assistance during the first project year.[1]

Specifically, the Division of Parent and Child Health Services of the Washington DOH requested technical assistance in developing a system to monitor the effects on providers and clients of Seattle/King County's transition to Medicaid managed care. After extensive discussion with PCHS officials regarding possible technical assistance strategies, a team was assembled consisting of HSR staff and the staff of the University of Washington's Health policy Analysis Program (HPAP). Beginning in June 1993, this team addressed the following tasks:

---

[1] Additional states chosen to receive technical assistance during the first project year were: Delaware, Indiana, New Mexico, Vermont and Wyoming.

- The establishment of a project steering committee consisting of representatives from the state departments of Health and Social and Health Services, the Seattle King-County Department of Public Health, the Region X office of the U.S. Public Health Service, Children's Hospital and Medical Center in Seattle, and HSR;

- The collection of baseline data on the Healthy Options client population's access to care and health status, as well as information on its use of the local health care delivery system before the implementation of Healthy Options; and

- The development of a system that program managers, plan administrators, and policy makers can use to monitor access and quality in King County's Medicaid managed care program over time.

The first two tasks were conducted by HPAP. In the late summer of 1993, Project Director Ian Hill conducted a site visit to Seattle to attend a meeting of the project steering committee at which the preliminary baseline data collected by HPAP were presented and discussed. Over the course of the winter of 1993-1994, HPAP worked to finalize the baseline data set. After the completion of this task, HSR addressed the final task of the workplan: the development of a system with which to monitor Medicaid managed care in King County.

This document presents the results of this technical assistance effort. Chapter Two presents the baseline data set and discusses the implications of changes in these indicators under managed care. Chapter Three describes the elements of the monitoring system that we recommend be used to record these changes. First, however, an overview of Medicaid managed care in Washington is presented in this chapter to provide a context for this discussion.

B. Background on the Healthy Options Program

Before describing the baseline data set and monitoring system developed under this project, it is important that the reader have a detailed understanding of the public health infrastructure in Seattle/King County prior to the advent of managed care, as well as how the Healthy Options program is being implemented. Further, it is helpful to fully understand why PCHS officials believe it to be necessary to closely monitor how new managed care systems will affect low-income women and children enrolled in Medicaid. This section provides this background information.

1. The Public Health System in Seattle/King County

Medicaid-eligible persons in Seattle/King County, as well as those with no source of health care coverage, have traditionally relied on the county's system of public-sector health care providers. This system has expanded rapidly in recent years, partly in response to the rising need in King County's growing and increasingly diverse population, partly in response to greater incentives for providers to treat low-income women and children, and partly because public programs have been implemented through a growing network of public and private partnerships. The county's public health care system now encompasses the following major elements:

- ***The Seattle-King County Department of Public Health (SKCDPH).*** In addition to community-based monitoring, assessment, and health promotion and disease prevention efforts, SKCDPH provides personal health services at 13 sites. These services include medical and dental care, family planning, immunizations, public health nursing, and TB and STD clinics. In some of these programs, more than a third of SKCDPH clients are enrolled in Medicaid.

- ***Community and Migrant Health Centers.*** Eight federally-funded Community Health Centers (CHCs) provide primary and ancillary health services in 19 clinic sites throughout the county. Among the services provided are immunizations and other well-child services, health screening, specialty care, patient referrals, maternity care, dental care, mental health services, and counseling.

- ***Public Hospitals.*** The University of Washington and Harborview Medical Centers once provided the overwhelming proportion of hospital care to low-income people. Today, through relationships with the community clinic system and other public-

private partnerships, most of the large hospitals in King County provide services to significant numbers of Medicaid clients.

The role of these public providers is changing. The promise of universal coverage under the Washington Health Services Act will reduce, if not eliminate, the need for these agencies to act as providers of last resort to the uninsured. Consequently, the primary role of the SKCDPH, for example, is likely to shift to that of monitoring, assessment, and assurance of the health of the county's population. In addition, all of the providers listed above are participants in the Healthy Options provider network: SKCDPH is the primary care provider in the CareNet plan, the federally-funded CHCs have formed the Community Health Plan of Washington, and the public hospitals provide services to enrollees in all plans. Therefore, their role will evolve into that of case managers as well as primary care providers. The next section provides further detail about the Healthy Options program.

2. The Healthy Options Program

Like most Medicaid managed care initiatives, Washington's initially targets families needing access to primary and preventive care. Therefore, three Medicaid client groups were chosen for participation in King County's Healthy Options program: Aid to Families with Dependent Children-Regular (AFDC-R); AFDC-Employable (AFDC-E); and General Assistance for Pregnant Women (GA/S). Fewer than two percent of these clients were enrolled in managed care plans before implementation of Healthy Options. The next client group to move into Healthy Options will probably be children whose families are no longer eligible for public assistance but who qualify for Medicaid coverage as individuals.

These three eligibility groups account for about 67 percent of Medicaid recipients in King County. About 80 percent of these clients are in the AFDC-R and GA/S eligibility groups. A

1992 MAA study estimated the following age distribution for potential Healthy Options clients:

10.6%	infants and 1-year-olds
18.5%	ages 2-5
26.8%	ages 6-14
10.3%	ages 15-20
22.8%	ages 21-34
10.8%	35 years and older

Prior to the program's October 1993 start date, clients were given a choice of seven health plans in which to enroll; those who did not choose a plan were assigned one. Three months before the program was to be fully implemented, clients received materials explaining that, under Healthy Options, they would be required to choose a plan from which they and their families would receive all primary care services. Clients were advised to select plans that included their choice of primary care provider. They were asked to select one of the following seven plans:

- ***CareNet,*** incorporating several SKCDPH district health offices, the University of Washington, and Children's Hospital and Medical Center;
- ***Community Health Plan of Washington,*** offering primary care case management through a network of federally-funded Community Health Centers;
- ***Ethix Health Plans,*** representing individual and group practice providers, mostly located in Seattle's suburbs, as well as the Asian Community Health Plan and the Southeast Asian Community Health Plan;
- ***Group Health Cooperative of Puget Sound,*** a staff-model health maintenance organization;
- ***King County Medical Blue Shield,*** primarily including physician providers in Seattle and South King County;

- ***Pacific Health Plan,*** an HMO, including Pacific Medical Center, two large Seattle hospitals; and the University of Washington; and

- ***Providence Health Care Plan,*** part of the Sisters of Providence Health System, and including the University of Washington and Pacific Medical Center.

In addition, members of the Healthy Options client groups were advised of the option of applying to be exempt from the managed care program. Individuals may apply for exemptions from Healthy Options for the following reasons:

- The client is homeless or living in a temporary shelter;

- The client lives 25 miles or 45 minutes away from a provider;

- The client needs specialized medical care for a serious health problem or disability;

- The client's current specialty provider is not participating in one of the seven managed care plans, but continued treatment with this provider is essential to the client's physical or mental health;

- The client is pregnant and receiving prenatal care from a provider who is not participating in a plan; or

- The client speaks limited English or has a hearing impairment and is already established with a provider with whom he or she can communicate.

MAA has not yet determined the number of exemptions applied for and granted in King County. The agency estimates that of about 4,000 exemptions from Healthy Options granted statewide, about half are in King County.

In September 1993, MAA assigned health plans to those clients who had not selected one. As of December 1, 1993, 65,312 eligible clients were signed up with Healthy Options in King County, more than half of the Medicaid managed care program's statewide enrollment of about 120,000. As shown in Table 1-1, clients divided themselves among the seven participating plans relatively evenly.

Under the Healthy Options program, providers are paid on a capitation basis. MAA calculated the capitated rate for Healthy Options based on the agency's experience providing fee-for-service Medicaid coverage for this population. Services included in the capitated rate include inpatient care, outpatient care, physician services, laboratory and X-ray services, durable medical equipment, home health, hospice, and emergency room services. All Healthy Options clients receive coverage that is as comprehensive as that provided under the fee-for-service program; covered services that fall outside the capitation, such as mental health services, are reimbursed on a fee-for-service basis. Some enhanced services for women and children are included within the capitated rate, while others are reimbursed separately. For example, children's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program exams are part of Healthy Options and are reimbursed through the capitated rate. The state's First Steps program, established by the 1989 Maternity Care Access Act, will continue to provide maternity support services (including nursing services, nutritional services, psychosocial support, and home visits) and maternity case management on a fee-for-service basis above the Healthy Options capitation payment.

A referral from each client's primary care provider is necessary to access virtually all specialist services provided under Healthy Options, although the program allows certain exceptions to this requirement. Clients may still self-refer to local health department clinics for immunizations, sexually transmitted disease testing and treatment, tuberculosis testing and treatment, and HIV/AIDS counseling and testing. They may also receive family planning services from their primary care provider or a family planning clinic.

Table I-1 Enrollment in Plans under Healthy Options as of December 1, 1993		
Plan	*Total Enrollees*	*Percent of Total*
CareNet	7,553	12%
Community Health Plan of Washington	12,070	18%
Ethix Health Plans	13,422	20%
Group Health Cooperative of Puget Sound	6,286	10%
King County Medical Blue Shield	13,362	21%
Pacific Health Plan	4,515	7%
Providence Health Care Plan	8,104	12%
(Source: MAA)		

3. The Need for Monitoring

Despite Medicaid managed care's potential to improve access and quality of care for low-income people, many health policy makers have expressed concern about the potential negative impact of mandatory managed care programs. Concerns include the following:

- The use of a capitated reimbursement rate provides an incentive to control costs by limiting the use of services and may thus encourage undertreatment. This may be a particular problem for a low-income population that tends to have more extensive medical and psychosocial needs. Whether quality of care will be maintained under managed care will depend on how providers balance cost control and access to care.

- Under managed care, clients who were accustomed to unrestricted access to emergency room and other services will now be required to adhere to the requirements of a primary care case management system. A rapid shift to such restricted systems can result in substantial confusion among both clients and providers.

- Many of the providers participating in Healthy Options did not treat Medicaid clients under the fee-for-service system. These providers must learn to communicate effectively with new patients who often have very different cultural backgrounds, whose lives may be extremely unstable, or who may not yet embrace such preventive practices as bringing a healthy child to the doctor for well-child care.

- Managed care offers particular challenges to adults and children with chronic medical conditions that require continual access to specialists. In addition, those who live in remote areas or whose first language is not English may not have easy access to the providers in their plan. Although these groups could qualify for an exemption from Healthy Options, they may not take advantage of this option and may have difficulty using the new system. In addition, children receiving Supplemental Security Income (SSI) payments will be enrolled in a separate managed care program beginning in 1996.

A further concern of public policy makers is that the public health system has traditionally served as a link between primary care services and state and federal programs providing child care, nutrition, and a variety of family support services. In some Washington counties and other localities that have implemented Medicaid managed care, a rapid shift of clients to private providers has reduced access to these connections and services.

For these reasons, policy makers, program managers, and evaluators need outcome-based tools to monitor the impact of mandatory managed care on Medicaid clients and providers. This document establishes one such tool by providing a baseline data set describing how Healthy Options client groups fared under the former fee-for-service Medicaid system. It also proposes a system for the regular collection of information on the effects of managed care. In addition, since Healthy Options is a mandatory program for most Medicaid-eligible individuals, its implementation requires a waiver of the Medicaid statute's guarantees of freedom of choice, comparability of services, and statewideness under the federal/state Medicaid program. To fulfill the conditions of this waiver, the state of Washington will be required periodically to measure the program's effects on clients' access to services, quality of care, and costs. The monitoring system described below will, therefore, be useful to a broad audience, including program managers, plan administrators, and state Medicaid officials.

II. Baseline Data Set on MCH Clients and Providers

To measure the impact of Medicaid managed care in King County, it is first necessary to understand the health outcomes, access to care, and service utilization patterns of Medicaid clients under the former fee-for-service Medicaid system. Data for these indicators are provided in this chapter and constitute a baseline against which the impact of the Healthy Options program can be measured.

A. Methodology

The baseline data are presented in four categories:

- Health status measures;
- Utilization and access measures;
- Financing and cost measures; and
- Interviews with individuals qualified to address the benefits and risks of transforming Medicaid in King County from a fee-for-service to a managed care system, including program managers, service providers, case managers, advocates for poor people and children, policy makers, and heads of client families.

Table 2-1 shows the baseline indicators collected for this report and the sources of these data.

Under ideal circumstances, baseline information would include indicators exactly comparable to indicators developed from data collected after implementation of the managed care program for Healthy Options client groups. Two major factors impede development of such a perfect baseline data set:

- Healthy Options clients represent a subset (approximately 67 percent) of all Medicaid clients in King County. Although most providers collect information on service use for Medicaid clients or Medicaid clients who are also on AFDC, records do not identify the individual client groups that comprise Healthy Options. Therefore, many elements of the baseline data set do not specifically concern the Healthy Options client population.

- Records of services provided to Medicaid clients often track the number of *visits* or *services* provided, not unduplicated *clients*--the measure that would allow more accurate indications of client behavior during the transition to managed care (*e.g.*, costs per client or referral patterns). In addition, although Medicaid payment records show the types and volume of services provided and paid for, this claims information does not indicate whether clients received care at appropriate times or settings.

Table II-1
Indicators Included in Baseline Dataset

Indicator	*Source*
Health Status Measures Low Birthweight Deliveries as a Percentage of all Births, by Age and Race	First Steps Data Base
Percent of all Births that are to Adolescents	First Steps Data Base
Percent of Children Fully Immunized: Head Start/ECEAP	Head Start/ECEAP
Utilization and Access Measures Services Used by Healthy Options Client Groups, by Age	MAA Primary Care Options Program/Healthy Options Data Base
Visits for Non-Hospital Services, by Provider Type	MAA Primary Care Options Program/Healthy Options Data Base
EPSDT Utilization among King County Children	MAA
EPSDT Claims by Provider Type, Healthy Options Client Groups	"Using Medicaid Data to Manage Health Care Programs,"October 1993
1992 Prenatal Care Slots Available to King County Medicaid Clients	Community Obstetrics Referral Program of the Seattle Area Hospital Council, SKCDPH, and the King County Medical Society
Initiation of Prenatal Care by Women in Healthy Options Client Groups, King County, 1991 and 1992	First Steps Data Base
Percent of King County Women Initiating Prenatal Care by the Second Trimester, Later, or Not at All, by Age	First Steps Data Base
Utilization of Maternity Support Services and Maternity Case Management, King County, 1992	First Steps Data Base
Number and Distribution of Clients, by Primary Care Provider Type	"Using Medicaid Data to Manage Health Care Programs," October 1993
Proportion of WIC Clients Enrolled in Medicaid	Office of Nutrition Services, DOH
Financing and Cost Measures Percent Distribution of Claims and Costs, by Type of Service	"Using Medicaid Data to Manage Health Care Programs," October 1993
SKCDPH Caseload and Share of Revenue from Medicaid	SKCDPH

In view of these factors, our baseline information reveals, to the extent possible, the conditions experienced by Medicaid clients and providers under the former system of fee-for-service Medicaid.

B. Health Status Measures

Health services research shows clearly that low-income people are less likely than the general population to enjoy good health. Poverty is closely linked with lower life expectancy, higher rates of low Birthweight births, and higher rates of infant mortality and disability. In King County, where eight percent of all residents live below the federal poverty line, a majority of new Healthy Options clients live in poverty.

This section examines some of the indicators of the health status of Medicaid-eligible persons in Seattle/King County. For this population, perinatal indicators are the simplest to collect, as this information is regularly compiled from birth certificates. We therefore present the low birthweight rates of infants born to women in Healthy Options client groups as well as the proportion of births in this population that are to adolescents. In addition, we will present the immunization rates for Seattle children enrolled in the Head Start program.

1. Low Birthweight Rates

The rate of low birthweight births (LBW), which account for a majority of infant deaths and are a leading cause of lifelong disabilities, is one of the most significant maternal and child health indicators. Low-income women are far more likely than are other women to give birth to LBW babies. Although the LBW rate among Healthy Options clients is no higher than that for other Medicaid clients in King County, the total 1992 LBW rate of 7.8 percent is more than 30 percent higher than the rate for King County as a whole or the average rate for Washington State.

Table 2-2 shows LBW rates for births in Healthy Options client groups, both in total and by the age and race of the mother. Low birthweight rates are highest in the youngest and oldest age groups, and are especially high in African-American and Native American communities. A high rate of low birthweight births may indicate both poor maternal health status and ineffective prenatal service

delivery systems. It is hoped that Healthy Options, by assigning each enrollee to a primary care provider, will increase continuity of care for women and thus improve birth outcomes. An increase in the rate of low birthweight births, or in the disparity among age or racial groups, may indicate particular populations for whom access to timely prenatal care needs improvement. Consistent monitoring of these indicators will assist health plans and program managers in targeting their outreach efforts.

Table II-2
Low Birthweight Deliveries as a Percentage of All Births Among Healthy Options Client Groups

	1991 (All Births = 2,491)	*1992 (All Births = 2,351)*
Total		
Low Birthweight (1,500-2,499 grams)	6.3%	6.6%
Very Low Birthweight (<1,500 grams)	1.3%	1.2%
Total Low Birthweight	7.6%	7.8%
Age		
<16	11.1%	13.0%
16-17	7.5%	9.3%
18-19	5.9%	7.2%
20-24	7.3%	7.2%
25-29	8.5%	7.7%
30-34	7.0%	6.7%
35+	12.1%	12.4%
Race		
White	6.3%	5.6%
African American	10.4%	12.5%
Native American	10.8%	8.9%

(Source: The First Steps Data Base, which combines information from Medicaid claims files and birth certificates. Prepared by the Washington Department of Social and Health Services Office of Research and Data Analysis.)

2. Births to Adolescents

The second health status indicator is the proportion of births that are to teenagers, as shown in Table 2-3. The actual number of births is small, and births to teenagers as a share of all Healthy Options client group births remained very stable from 1991 to 1992.

Births to adolescents are not only an indicator of poor health status; they are strongly linked with increased rates of LBW and infant mortality, as well as increased risk of economic and social difficulties for both mother and child. However, adolescent childbearing is driven by complex social factors and does not necessarily reflect either the availability or quality of health services. Nonetheless, a significant change in the number or proportion of births to teenagers enrolled in Healthy Options plans could indicate changes in access to family planning, counseling, and other preventive services.

Table II-3
Births to Adolescents, Healthy Options Client Groups

	1991		1992	
Age of Mother	*Number*	*Percent of Births*	*Number*	*Percent of Births*
< 16 years old	27	1.1%	23	1.0%
16	63	2.5	52	2.2
17	84	3.3	111	4.7
18	163	6.4	181	7.6
19	251	9.8	211	8.8
Total	588	23.1%	578	24.3%

(Source: First Steps Data Base)

3. Immunization Rates

Immunization rates are an indicator both of the proportion of children that are protected against infectious disease as well as the percentage who are receiving well-child care. It is hoped that the availability of a regular source of primary care for Healthy Options enrollees will result in an increase in immunization rates in the enrollee population. Conversely, a decrease in immunization

rates in the program as a whole or in an individual plan may indicate the need for greater outreach and education of clients and providers regarding the need for regular preventive care.

The best source of data currently available on immunization rates for children likely to be enrolled in Medicaid is the Head Start and Early Childhood Education Assistance Programs (ECEAP), which provide pre-school and related care to low-income children, since the majority of children in Head Start/ECEAP are in families receiving public assistance. When children enter Head Start/ECEAP programs at age 3 or 4, the agencies require records of up-to-date immunizations, recent well-child exams, and health screens. Because full immunization is a requirement for enrollment in early childhood education programs, these records do not provide a representative sample of the immunization rate among young children in the county. At this time, however, better baseline data are not yet available on the county level, although major efforts are being made in this regard.

As displayed in Table 2-4, a study of immunization data collected for children in Seattle's 13 Head Start agencies in January 1993 shows that the immunization rates for AFDC families appear to be consistent with rates for children statewide. In 1991, statewide immunization rates for all children were 51% at age 2 and 94% at entry to kindergarten, usually age 5.

Table II-4
Percent of Children Fully Immunized
Seattle Public Schools Head Start/ECEAP*
January 1993

Percent fully immunized at age 2	54.3%
Percent fully immunized at enrollment**	84.3%

* N=965
** Children who had received all immunizations recommended for their age at the time health forms were filed with participating agencies. Most children in Head Start/ECEAP are four years old.
(Source: Head Start/ECEAP monthly reports)

C. Utilization and Access Measures

This section provides baseline information regarding patterns of service use under fee-for-service Medicaid, including the proportion of visits that take place in hospitals and the use of prenatal and well-child services. These data will provide a backdrop against which to evaluate the appropriateness of service utilization under Healthy Options and the extent to which managed care encourages the use of primary care providers and preventive health services.

1. Total Users of Services

The first indicator in this section is the total number of enrollees in Healthy Options client groups who used services in 1991. From its eligibility records, MAA reports that the average number of people eligible under Healthy Options client groups each month in 1991 was 63,570. The number of actual *users* of Medicaid-financed services, as reported in fee-for-service claims files, in these client groups is shown in Table 2-5. By far the largest number of these users sought services outside of hospitals.

The Medicaid managed care program is designed to encourage clients to seek more preventive care and see providers earlier when they have health problems. If this occurs, data collected after implementation of Healthy Options should indicate even higher use rates for, and a greater share of services provided in, outpatient settings, clinics, and physicians' offices.

Table II-5
Services Used by Healthy Options Client Groups* By Age
King County, 1991

Age	*Inpatient Hospital**	*Outpatient Hospital**	*Non-Hospital**
0-1	95	314	3,003
2-12	259	822	9,466
13-19	186	335	3,467
20+	688	1,299	12,538
Total	1,228	2,770	28,474

* Total average monthly users
(Source: MAA Primary Care Options Program/ Healthy Options data base)

2. Non-Hospital Services

From the same database, MAA staff have broken out the number of Medicaid-financed visits for non-hospital services by provider type. As Table 2-6 shows, the largest share took place in clinic settings. Most visits to non-clinic-based physicians were for primary care.

A significant change in the proportion of Medicaid-funded visits to specialist physicians should lead to further inquiries into the accessibility of both primary and specialist services under Healthy Options. The use of specialists may well decrease as primary care providers effectively assume responsibility for case management and take on the role of "gatekeeper" for their clients. In a primary-care case management model, however, if primary care services themselves are not sufficiently accessible, access to specialists' services will also be restricted. In addition, the Healthy Options program may well cause a decrease in the proportion of visits that take place in clinics, as the plans that include the Community Health Centers and SKCDPH clinics enrolled a minority of Healthy Options clients. However, this decrease should be balanced by an increase in visits to private primary care physicians.

Table II-6 Visits for Non-Hospital Services by Provider Type King County Healthy Options Client Groups, 1991	
Type of Provider	*Number of Medicaid-Financed Visits*
Primary Care Physicians Total	140,033 (35.1%)
Family Practice	36,788
General Practice	50,393
General Practice/ER staff	43,208
Internal Medicine	9,644
Clinics Total	167,910 (42.1%)
EPSDT*	2,947
Family Planning	1,767
Federal Qualified Health Center	34,519
Indian Health Center	459
Physician Clinic	128,197
Rural Health Clinic	21
Specialty Physicians Total**	90,539 (22.7%)
TOTAL	398,482 (100%)

* Services provided through EPSDT clinics only
** Includes pediatricians
(Source: MAA Primary Care Options Program/ Healthy Options data base)

3. EPSDT Screens

Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a mandatory prevention and treatment program for all clients under 21 years old. EPSDT encompasses comprehensive evaluations of children's health, developmental, and nutritional status, including necessary vision and hearing screens, immunizations, and diagnostic screens, as part of well-child exams reimbursed under the program. The Omnibus Budget Reconciliation Act of 1989 (OBRA-89), which took effect in 1990, specified schedules for vision, health, and hearing exams and required states to facilitate access to treatment. Records of EPSDT services provide baseline information on the number of Medicaid-eligible children who are receiving preventive care.

Table 2-7 shows the number and proportion of children in families receiving AFDC who received at least one EPSDT screen during fiscal year 1992. It also shows the number and proportion of all Medicaid clients who received at least one EPSDT exam by age. Table 2-8 shows the distribution of EPSDT claims by provider type for Healthy Options client groups who used the county's public health care system (public health department, Community Health Centers, and the University of Washington) in the first six months of 1992.

Table II-7
EPSDT Utilization among King County Children

	Unduplicated No. of Users, FY 1992	*% Eligibles Who Are Users, FY 1992*
AFDC Recipients	16,961	31%
All Medicaid Clients, by Age:		
Infants	4,054	62%
Ages 1-5	11,925	45%
Ages 6-10	3,007	17%
Ages 11-14	1,678	16%
Ages 15-20	2,122	16%

(Source: MAA)

If Medicaid managed care is successful in promoting preventive services, data on Healthy Options service use will show an increased proportion of eligible clients receiving well-child exams. Conversely, a decrease in the proportion of children receiving EPSDT exams may signal decreased access to preventive and primary care under the new program. The distribution of providers of EPSDT services may well change as private physicians become increasingly involved in the Medicaid program; therefore, program managers should monitor both the absolute number of screens provided as well as the proportion delivered by each type of provider.

Table II-8 EPSDT Claims by Provider Type, Healthy Options Client Groups January-June 1992	
Type of Provider	*Number/Percent of Claims*
SKCDPH	8,073 (42%)
Community Health Centers	3,861 (20%)
Private Providers	7,299 (38%)
Total	19,233 (100%)
(Source: "Using Medicaid Data to Manage Medicaid Health Care Programs," October 1993)	

4. Prenatal Services

Tables 2-9 through 2-11 present information on the availability and use of prenatal care among women in the Healthy Options client groups. Table 2-9 shows the number of prenatal care slots available to Medicaid clients in the current system; as the table shows, this number is close to adequate for the number of births financed by Medicaid in King County in 1992. In recent years, King County has experienced a rapid expansion in the number of maternity care providers willing to serve Medicaid women. Policy makers hope that this supply will be maintained, or even improved, if providers are willing to sign up with participating Healthy Options plans. However, the availability of providers is only one factor contributing to access. Clients must have the means to travel to a provider, to communicate, and to obtain child care services during appointments. Often, they need encouragement or outreach to see a doctor when they are healthy or if a visit is inconvenient or threatening. For these and other reasons, "access to care" cannot be measured simply in terms of the concentration of providers in a community who will treat Medicaid clients.

For this reason, we also present the extent to which Medicaid-eligible women actually used timely prenatal care. Tables 2-10 and 2-11 address the timing of initiation of prenatal care by women in Healthy Options client groups in King County: Table 2-10 shows the distribution of pregnant women in 1991 and 1992 who began prenatal care, by trimester, and Table 2-11 shows, by age, the percentage of pregnant women who did not initiate care in the first trimester. These data show that

the share of women in Healthy Options client groups receiving timely prenatal care has risen, but more than half of these women are still initiating care after their first trimester of pregnancy. Consistent tracking of these indicators will allow program managers to assess the efforts of each plan in educating women about the need for early prenatal care and in providing this care to those who need it most.

Table II-9
1992 Prenatal Care Slots Available to King County Medicaid Clients*

Community Health Centers	1,090
Seattle-King County Department of Public Health Sites	550
	2,968
Hospital-based Clinics	1,610
Private Physicians	
Total Slots Available	6,218
Estimated Number of Medicaid-financed Births in King County	6,397**

* One slot = one client
**Preliminary data from First Steps Data Base
(Source: Community Obstetrics Referral Program of the Seattle-Area Hospital Council, SKCDPH, and the King County Medical Society)

Table II-10
Initiation of Prenatal Care by Women in Healthy Options Client Groups, King County, 1991 and 1992

	1991		1992	
Trimester Care Began	*Number*	*Percent*	*Number*	*Percent*
First	1,167	45.7%	1,178	49.4%
Second	693	27.2	564	23.6
Third	201	7.9	205	8.6
Missing	475	18.6	407	17.1
None	16	0.6	32	1.3
Total	2,552	100.0%	2,386	100.0%

(Source: First Steps Data Base)

Table II-11 Percent of King County Women Initiating Prenatal Care by the Second Trimester, Later, or Not at All, by Age		
Age	*1991*	*1992*
<16	66.7%	60.9%
16-17	51.0	51.5
18-19	54.8	46.4
20-24	53.9	50.3
25-29	53.6	52.7
30-34	56.2	52.7
35+	53.8	49.7
All Births	54.2%	50.6%
(Source: First Steps Data Base)		

5. Enhanced Prenatal Services

Along with an expansion of eligibility and incentives for providers to participate in Medicaid, the 1989 Maternity Care Access Act was designed to encourage childbirth education and, for high-risk women, to increase the development of maternity support services and community-based maternity case management. The Act established two new programs:

- ***Maternity Support Services (MSS),*** which provides Medicaid-financed nursing, nutrition, psychosocial, and community health worker visits. King County MSS providers include the health department, six hospital-based programs, and three independent agencies. All Medicaid-eligible women may receive MSS services.

- ***Maternity case management (MCM)***, which provides Medicaid-financed outreach and referral, intake assessment, intervention planning, counseling, monitoring, and outcome evaluation for all high-risk pregnant women on Medicaid. About one-third of the women who receive maternity support services also receive maternity case management.

Under Healthy Options, MSS and MCM services continue to be available to pregnant women on a fee-for-service basis. Primary care providers are encouraged to refer eligible clients to case managers and MSS providers working in the health department, hospital-based programs and other

contracted agencies. As of March 1993, King County had 34 providers of MCM services, 30 providers of MSS, and 13 providers of childbirth education. The number and proportion of Medicaid-enrolled women in King County who used these two programs in 1992 are shown in Table 2-12.

First Steps has become an effective mechanism to provide critical support services to socially and medically high-risk women in King County. Maternal and child health officials should monitor the availability of First Steps providers, and the proportion of eligible women who use their services, to see that this momentum is not disrupted by implementation of Medicaid managed care.

Table II-12
Utilization of Maternity Support Services and Maternity Case Management
King County, 1992

Program	*Number of Users*	*Percentage of Medicaid Women who Used Services*
Maternity Support Services	4,436	69.3%
Maternity Case Management	2,138	33.4%

(Source: First Steps Data Base

6. Use of Public Providers

Table 2-13 shows the distribution of Medicaid service users by the type of primary care provider used in the period January-June 1992. This table is based on a data set tracking Healthy Options client groups who used SKCDPH, Community Health Center, and public hospital services. This table shows that, among those who ever used the public health system, the majority used SKCDPH or Community Health Centers for primary care. This may reflect the preference of Medicaid enrollees for public-sector providers, or may provide evidence of Medicaid enrollees' lack of access to private physicians under the current Medicaid fee-for-service system. Under Healthy Options, it is likely that the distribution of clients will shift from public to private providers, as clients are

allowed to choose among several health plans, most of which feature private-sector providers of primary care.

Table II-13
Number and Distribution of Clients by Primary Care Provider Type
Healthy Options/King County Client Groups, January-June 1992

	Number of Unduplicated Clients	*Proportion of Total*
Seattle-King Co. Department of Public Health	6,557	36%
Community Clinics	4,464	25
Private Providers	7,072	39

(Source: "Using Medicaid Data to Manage Medicaid Health Care Programs," October 1993)

7. Supplemental Food Program for Women, Infants, and Children

Table 2-14 shows the number and percent of participants in the Supplemental Food Program for Women, Infants, and Children (WIC) who are enrolled in Medicaid. Low-income individuals and families may qualify for a range of publicly-supported health and social services along with Medicaid. Pregnant women and young children, in particular, are likely to be eligible for WIC, which provides vouchers for specially-prescribed foods for pregnant and breastfeeding women, infants, and children under age five in families with incomes below 185 percent of the federal poverty level. WIC is often the first program to which low-income pregnant women apply; WIC staff then refer families to Medicaid or other programs for which they may be eligible.

This indicator will help to gauge the effectiveness of referral networks under managed care. As Table 2-14 shows, a larger proportion of WIC enrollees were also enrolled in Medicaid in July 1992 (when the First Steps program initiated its outreach efforts) than in July 1993 (after the major outreach effort ended.) It is hoped that the implementation of Healthy Options will bring another such outreach effort, and that the proportion of WIC enrollees in Medicaid will begin to rise.

Table II-14 Number and Percent of King County WIC Participants Enrolled in Medicaid			
Month	*Total Number of WIC Enrollees*	*Number of WIC Enrollees on Medicaid*	*Percent of WIC Enrollees on Medicaid*
July 1992	15,729	11,594	74%
July 1993	19,504	12,046	62%
Source: Office Of Nutrition Services, Washington Department of Health			

D. Financing and Cost Measures

This section presents two measures of Medicaid expenditures for services to its recipients across various types of service. One indicator covers services to all Medicaid recipients, and the other focuses on those who used the Seattle-King County Department of Public Health. Using these baseline indicators, Healthy Options program and health plan managers will be able to assess their programs' use of Medicaid funds.

1. Distribution of Medicaid Costs

Table 2-15 shows the distribution of Medicaid costs by type of service provided to all King County Medicaid clients during the first six months of 1992. These data show that, under fee-for-service Medicaid, inpatient care accounted for 1 percent of the program's billing volume but 50 percent of total costs. In a capitated system such as Healthy Options, of course, providers will no longer file claims for individual services, so the monitoring system will be unable to measure the amount of Medicaid expenditures attributable to each type of service. Plans will, however, be required to report the number of client contacts for EPSDT, immunizations, and family planning services; the other types of service will not be regularly monitored.

Table II-15
Percent Distribution of Bills and Costs by Type of Service, All Clients*
January-June 1992

Type of Service	*Percent of Claims*	*Percent of Total Costs*
Primary Care	36.2%	18.3%
Prescriptions	25.6	1.2
Specialty Care	8.1	5.3
Lab	7.3	6.1
Outpatient	7.1	9.6
Emergency Room	6.2	6.6
EPSDT	5.7	1.3
Other Services	2.4	1.3
Inpatient	1.1	50.0
Home/Institution	.2	.3
Family Planning	.1	.2
	100.0%	100.0%

* Data are bills generated by Healthy Options client groups who used elements of the county's public health delivery system: community clinics, the public health department, and hospitals in the University of Washington system. N=22,408, including clients who received little or no primary care through the public health system.
(Source: Report on "Using Medicaid Data to Manage Medicaid Health Care Programs," October 1993)

2. Revenue From Medicaid

Table 2-16 shows the proportion of revenue in SKCDPH primary care programs that comes from Medicaid-reimbursed services. Under Healthy Options, the amount of the Department's financing that comes from Medicaid is likely to decrease, as will the Department's patient load for primary care services. However, under the state's Public Health Improvement Plan, the state will provide funding to offset lost Medicaid reimbursements in order to support population-based public health programs in local health departments. A total of $10 million has been appropriated for this purpose for fiscal year 1994, to be divided among the state's 32 health departments and districts according to the size of the populations they serve. King County received $1,427,872 from this fund.

Again, under Healthy Options, SKCDPH will no longer be reimbursed on a fee-for-service basis and will, therefore, be unable to report the total amount of funding used for each service type. The total

number of clients using family planning and immunization services will be regularly reported, however, and will be included in the monitoring system.

Table II-16
Seattle-King County Department of Public Health
1992 Primary Care Program
Caseloads and Share of Revenue from Medicaid

	Number of Unduplicated Patients	*Total Revenue*	*Percent of Revenue from Medicaid*
Pediatrics	13,614	$4,628,493	21.8%
Maternity	984	$1,194,584	28.0%
Family Health	4,721	$1,120,580	10.1%
Family Planning	15,558	$3,517,726	4.3%
Immunizations	50,367	$2,430,896	8.4%

(Source: SKCDPH)

E. Interviews

This section presents two qualitative elements of the baseline data set: the results of interviews with key informants on the current and future Medicaid systems in King County, and case studies of six families of children with special health care needs to assess the potential effects of the new system on this population.

1. Survey of Key Informants

To complete the baseline data set, HPAP conducted interviews with 24 policy makers, program managers, health care providers, and client advocates to study the effectiveness of Medicaid in King County before the transition to managed care. In interviews conducted during August and September 1993, these individuals shared their views on the strengths and weaknesses of fee-for-service Medicaid. (See Appendix A for a list of interviewees and the complete pre-implementation

survey.) In these interviews, HPAP asked specific questions about the effectiveness of fee-for-service Medicaid programs in King County, including:

- Were Medicaid clients sufficiently informed about their benefits, and were they adequately apprised of mechanisms to report complaints and grievances?
- Did these programs provide families on Medicaid with timely access to well-child and other primary care, specialty care, hospital services, and emergency care?
- Was the quality of care provided under these programs adequate?

HPAP also asked these key informants to discuss their concerns and expectations about the future of Medicaid under managed care.

The key informants were in general agreement that fee-for-service Medicaid provided adequate access and quality of care to clients who were motivated ("systems smart") or associated with a strong advocate who helped them secure benefits. Most contended that clients had only a minimal understanding of the program and often found the literature explaining its benefits to be obscure and incomprehensible. Those with a regular need for health services, many informants noted, were quite dependent on providers who were equipped with the background and cultural skills to interact with low-income people.

Nearly all of those interviewed anticipated that the implementation of Healthy Options would be fraught with confusion for both clients and providers. Most, however, expect Medicaid managed care to afford its clients greater access to care and expect that the new system will emphasize prevention and be more cost-effective than fee-for-service Medicaid.

Specific responses in the areas of information and grievance resolution, access to care, quality of care, and the future under managed care are presented below.

a. Information and Grievance Resolution

The key informants reported inadequate communication on the part of the Medicaid program regarding benefits or the resolution of grievances. However, provider agencies often can communicate effectively with their clients regarding the Medicaid program. Specifically:

- A majority of key informants stated that Medicaid clients in the fee-for-service system had not received adequate effective communication about their health care coverage. Several noted that clients received information but did not read or absorb it; in the words of one key informant, the information was "available but not accessible." Several of those interviewed reported that the written material sent to clients was usually too complex and esoteric for clients with learning problems or minimal education to comprehend.

- Half of the key informants said clients with complaints about their health coverage had encountered difficulty resolving them. The state bureaucracy, reported several program managers and coordinators, can be very cumbersome and intimidating to people on public assistance.

- Several interviewees commended efforts by the SKCDPH and the Community Health Centers to address language and other cultural barriers in communicating with clients.

b. Access to Care

Several key informants stated that Medicaid clients' access to care in the fee-for-service system was satisfactory. Two major barriers to access were noted, however: a lack of providers willing to serve Medicaid clients, and a lack of client appreciation or understanding of the importance of preventive care. Most also argued that more effort should be invested in addressing non-financial barriers to access, including transportation.

- When asked whether Medicaid clients in the fee-for-service system received adequate access to *well child care*, 15 of 24 key informants said they did, although services are not always used. Several respondents remarked that clients were often not accustomed to making appointments in advance of visits, that there was a shortage of primary care providers in less-populated parts of the county, and that cultural and language barriers have stood in the way of clients' access to care.

- Asked whether Medicaid recipients had adequate access to *specialty care* under fee-for-service arrangements, 17 key informants said they did. Several noted difficulties in obtaining referrals, however.

- Nineteen key informants said that Medicaid clients in the fee-for-service system had adequate access to *hospital care*. A nurse in one of Seattle's high- school-based clinics stated, however, that she had "problems getting kids hospitalized" that she had not encountered with "middle-class" families.

- Fully 21 of the 24 key informants replied that Medicaid clients in King County have adequate access to *emergency room care*. Most, however, explained that care in this setting is often "inappropriate" and would be discouraged with better education of clients.

c. *Quality of Care*

Most key informants regarded the quality of health care in King County under the Medicaid fee-for-service system as adequate and up to the general standards of the community for those clients fortunate enough to connect with providers. Several noted that, as is the case for residents with private insurance, quality varies considerably among providers.

- When asked about the quality of *well-child care* under fee-for-service Medicaid, less than half (eleven) of the key informants replied that it was adequate. (One-third of those interviewed said they did not know.)

- When asked about care for *children with special or chronic medical needs*, half replied that care is adequate but several key informants said that parents have to be "aggressive" or "persistent" in securing care. For *adults with special medical needs*, only seven key informants said they received adequate care, with several answering that obtaining satisfactory care for chronically ill adults is much more difficult than obtaining it for children.

d. Future Under Managed Care

Overall, key informants expect Healthy Options to result in better access to care for King County's low-income families; 15 predicted that access to care will improve and eleven predicted that health status will also improve. When asked how Healthy Options will affect quality of care for Medicaid clients, nine predicted that quality will become better, three thought it would become worse, and five said it would remain about the same.

Nearly all key informants predicted a tumultuous debut for Healthy Options. A majority anticipate substantial confusion on the part of clients as they adjust to new providers and change long-established care-seeking habits. One community clinic physician suggested that many providers will have to learn effective and appropriate ways to work with low-income clients who may have psychosocial and substance abuse problems. While clients attempt to learn the new system, primary care may be disrupted. Specialty care, in the first few months, may be underused and some client-provider relationships will be severed.

Nonetheless, most key informants expect Healthy Options to improve access to care. Although several see King County's health services delivery system becoming more competitive and centralized, Medicaid clients, they predict, "will have more options and clout."

2. Case Studies of Families with Special Health Care Needs

As part of its baseline data set for Healthy Options, HPAP staff also interviewed members of six King County families with children with special health care needs enrolled in fee-for-service Medicaid before October 1, 1993. At least 1 percent of all children in the county have ongoing chronic health conditions that require frequent access to specialists, use of the emergency room, and sometimes life-long reliance on costly prescription drugs and durable medical equipment. Serving these children in managed care plans presents a special challenge. For this reason, Healthy Options allows parents or guardians to request and obtain an exemption from the program. However, the Washington State's Health Services Act requires that all children receiving Supplemental Security

Income (SSI) benefits be enrolled in managed care by 1996. Medicaid officials and program managers will, therefore, have more time to plan for the transition of this population into managed care.

MCH officials are particularly concerned about the consequences of Medicaid managed care for families with special needs children. These children are disproportionately represented in Medicaid programs because of the financial toll their health conditions take on their families. The extraordinary costs of private medical insurance for persons with serious pre-existing conditions, as well as the continuing costs of care, often make Medicaid the only feasible source of health care financing for families with chronically ill children.

Many of these children need frequent access to specialists. The costs of their treatment, including substantial spending on durable medical equipment, could conflict with the cost-saving goal of capitation. In addition, primary care "gatekeeper" model could, intentionally or unintentionally, limit access for children with frequent need for specialty care. Often, families with special needs children have developed complex networks of care among many providers that could be shattered if they suddenly moved into managed care plans. Therefore, the particular services used by children with special health care needs should be taken into account in the design of the managed care program for this population.

The families included in the focus group reported the following about their experiences in the fee-for-service Medicaid system:

- All families stated emphatically that they could not care for their children without Medicaid financing.
- Three families reported that they have recently experienced a reduction in benefits, particularly for durable medical equipment. In all three cases, the new limits have caused concern and inconvenience for family members. In one case, a parent reported that her child had been exposed to risk.

- All families noted that Medicaid rules tend to be rigid and more focused on "conditions" than on the needs of individual children.

- Two parents reported that they have received little guidance or support in cases of medical emergencies.

- None of the families interviewed expressed concerns about Medicaid managed care. However, neither had any of them been briefed on Healthy Options. Not surprisingly, therefore, no one mentioned seeking exemptions from the program.

III. Monitoring System for Policy Makers and Program Managers

A. Introduction

The implementation of Medicaid managed care in King County will present challenges to both the state MCH office and the SKCDPH. In order to adapt to the changing needs of their clients, these agencies must have access to reliable information that describes the effects of the program on its enrollees. This section presents a comprehensive monitoring tool that will allow program managers and public health officials to monitor the impact of Healthy Options and respond to any problems that might arise.

Currently, Washington State has no single source that can provide state and local public health officials with all of the information they will need to evaluate the impact of the Healthy Options program on low-income women and children. In the absence of such a data source, the State requires a structured method of collecting and analyzing information from different sources and using that information to make recommendations regarding public health system intervention if problems arise.

This monitoring tool provides a method of assembling data from a variety of sources in a format that will allow public health officials at the state and local levels to identify those areas in which public health interventions may be appropriate. By combining data from a variety of sources, the tool allows public health officials to identify trends in service delivery and health outcomes that would not be apparent in studying data from a single information source. The complete analysis is

accomplished by comparing newly collected data with the baseline information contained in the earlier section of this report. In addition, some of these data will be used to compare a current indicator with standards established either by the programs themselves or through Washington State's Public Health Improvement Plan. In this chapter, we provide several sample table shells that present data in a format that allows for the analysis of specific access, cost and quality assurance indicators by public health program managers.

B. New Sources of Data

As Washington State's health care delivery system changes, the data available from that system will change as well. For instance, the Health Services Information System currently under development will provide program managers with new information about clients being served in the reformed health system. Medicaid managed care systems will also collect information about participants in individual managed care plans. Other public health programs, such as WIC, will also develop new systems to operate in the new managed care settings. While this report does not attempt to identify all potential new data sources, it does identify certain critical information systems of which program managers should take full advantage.

Specifically, the monitoring tool will include the following:

- ***The Health Services Information System (HSIS).*** The HSIS is Washington State's comprehensive information system to provide population-based information to support public health functions. As the HSIS evolves, it will replace many of the current data collection systems that do not provide a comprehensive view of the client population. Several of its components will provide information on the health status of mothers and children. For example, the plan includes a component that tracks the immunization and risk status of children. The immunization status of children at age two has been identified by both the state MCH and Medicaid programs as a key indicator of a child's health status.

- ***Medicaid Managed Care Quality Assurance.*** The Medicaid program proposes to use maternal health indicators and immunization status to evaluate the quality of care in the individual health plans. This plan-specific information will be important in order to assess each plan's ability to respond to the needs of its clients.

- ***WIC Program Local Options.*** Both the current and proposed WIC systems will allow the local health department to measure a variety of specific indicators. The WIC program and the Medicaid program use the same income guidelines; currently, 63 percent of the WIC participants served by SKCDPH are receiving Medicaid. The Seattle/King County WIC Program can modify its data system to collect additional information on Healthy Options clients, such as the plan in which they are enrolled and the immunization status of their children.

Each of these new sources of information, combined with current information sources, will assist state and local officials in measuring the indicators included in the monitoring tool. As these systems evolve, state and local officials should examine these potential sources of new data and identify additional indicators that may be available.

C. Components of the Monitoring Tool

The goal of a monitoring tool is to bring together a broad range of different types of information that, combined, will provide a comprehensive picture of the health status of mothers and children. A tool that will provide state and local officials with the means to evaluate the impact of managed care on mothers and children must include several components and utilize a variety of information sources, both current and planned, including:

- A population-based assessment of the ongoing health status of women and children, as well as an assessment of the health status of clients within specific sub-populations;
- An assessment of the clients' perception of the service delivery system, as obtained through a client satisfaction survey;
- An assessment of providers' perceptions of the Healthy Options program, obtained through a key informants survey;
- An assessment of the relative performance of individual plans in the Healthy Options system, obtained from plan-specific data provided by Medicaid; and
- As assessment of the effectiveness of Healthy Options in serving children with special health needs (CSHCN), obtained through both a survey of physicians who serve such children as well as the conduct of case studies of families with CSHCN.

Each of these components will help to build a picture of the health status of the maternal and child population and of how well the managed care system is serving them. It allows the public health system to examine issues related to access, cost and quality from several different viewpoints; the information can also be combined to provide both a population-based assessment of the client status and a plan-specific analysis of issues. In addition, the various components of the tool will show how the various participants in the health care delivery system view the successes and problems that may occur in the system over time. The following is a discussion of each of the components of the monitoring system and the indicators that will support them.

1. Population-Based Assessment

Population-based assessment is an important, objective approach to assessing the health status of the maternal and child health population. Population-based assessment should consist of indicators that can be measured with existing data or proposed data sources. These indicators will include both those that measure progress over time and point-in-time measurements that can be compared with established standards. Some of the indicators of access to care, cost, and quality of care already have baseline data established, as indicated in Chapter Two of this report. However, this monitoring tool also identifies additional indicators for which baseline data are not currently available, but that will become available from new sources of information in the near future.

The following tables display the key population-based indicators. The table lists each indicator, the source of the data, the type of indicator, what it is intended to measure, and whether or not baseline data currently exist. For purposes of clarity, the indicators are divided into specific maternal and child population groups, including: perinatal, children and adolescents, children with special health care needs, and the population as a whole.

a. *Perinatal Services*

Of the indicators listed in Table 3-1, only the "Number of Emergency Room Deliveries" is not included in the baseline data set. This information may be obtained from both the First Steps database and from each participating health plan. The number of emergency room deliveries should drop if the managed care plans are providing the support necessary for pregnant women to receive high-quality, timely prenatal care services.

Table III-1
Perinatal Indicators

Indicator	*Sources of Data*	*Type of Indicator*	*Measure*	*Baseline Data?*
Low Birth Weight	First Steps Data Base	Trend Analysis	Access to Services and Quality of Care	Yes
Low Birth Weight by Race	First Steps Data Base	Trend Analysis	Access to Services and Outreach Needs	Yes
Number of Prenatal Care Slots Available	OB Referral Program, SKCHD, and King County Medical Society	Trend Analysis	Access to Services	Yes
Initiation of Prenatal Care	First Steps Data Base	Point in Time For Comparison With Standards	Access to Services and Quality of Care	Yes
Percent of Eligible Women using MSS and MCM	First Steps Data Base	Trend Analysis	Quality of Care	Yes
Number of First Steps Providers	First Steps Data Base	Trend Analysis	Access to Services	Yes
Number of Emergency Room Deliveries	First Steps Data Base	Trend Analysis	Quality of Care	No

b. *Child and Adolescent Services*

Of the indicators in Table 3-2, the only one not included in the baseline data set is "Referral to Early Intervention Services." This information may be obtained from the reporting that the state Birth to Six Program requires of its contractors. This information is needed to assure that infants and children that are diagnosed with problems are referred to appropriate early intervention services by the health plans.

Table III-2
Child and Adolescent Indicators

Indicator	*Source of Data*	*Type of Indicator*	*Measure*	*Baseline Data?*
Immunization Status	Head Start/ECEAP, WIC, HSIS	Point in Time to Compare With Standards	Quality of Care	Yes
EPSDT Utilization Rate	Medicaid Data Base	Trend Analysis	Quality of Care	Yes
Percent of Births That Are to Adolescents	First Steps Data Base	Trend Analysis	Access to Necessary Services	Yes
Low Birth Weight By Age	First Steps Data Base	Trend Analysis	Quality of Care and Access to Services	Yes
Referrals to Early Intervention Services	Birth to Six Data Base	Trend Analysis	Access to Necessary Services	No

c. *Children With Special Health Care Needs*

Very little population-based information on children with special health care needs is currently available, particularly within the sub-category of those participating in Healthy Options. Most of the indicators used to evaluate the status of these children will be based on data from other sources. However, as indicated in Table 3-3, trends in the hospitalization

rate of these children should give state and local program staff an indication of how well the plans are working with the established case management programs, and will help them to monitor the accessibility of specialist care.

Table III-3
Indicator for Children With Special Health Care Needs

Indicator	*Source of Data*	*Type of Indicator*	*Measure*	*Baseline Data?*
Hospitalization Rates	Hospital Discharge Data	Trend Analysis	Quality of Care	No

d. The Client Population as a Whole

Of the indicators in Table 3-4, only the "Percent of WIC clients Enrolled in Healthy Options" is not included in the baseline data set. This information can be obtained from the SKCDPH WIC Program through the use of the "local options" section of the WIC data collection form. This information is important to evaluate the effectiveness of health plans' outreach efforts in enrolling clients and assuring access to prenatal care. In addition, most of the expansion of the WIC Program over the next few years will be directed at children ages three through five. By evaluating the enrollment status of these children, program managers can determine if they have adequate access to necessary primary care services.

Table III-4 Population-Wide Indicators				
Indicator	*Source of Data*	*Type of Indicator*	*Measure*	*Baseline Data?*
Number and Distribution of Clients by Primary Care Type	Seattle/King County Health Department	Trend Analysis	Cost of Services and Access to Care	Yes
Percent of WIC Clients Enrolled in Healthy Options	Seattle/King County Health Department WIC Program	Trend Analysis	Access to Necessary Services	Yes

2. Client Surveys

One of the most direct ways to determine if the Healthy Options program is meeting the needs of mothers and children is to ask the clients themselves about how they feel they are being served. To that end, a client survey is a sensible means for direct client input into the monitoring system. The use of client surveys will assist in the identification of both access and quality issues. While the Healthy Options program will conduct client interviews and case studies to determine the quality of care within specific health plans, it should be the role of the public health department to assess, system-wide, how well clients can access information about the plans, and the ability of the plans to meet all of the needs of its clients. A survey of those health department clients that are either eligible for Health Options or are currently participating in a Healthy Options provider plan will provide state and local officials with a system-wide view of client access.

The final design of the client survey should include:

- A sample of clients that have participated in the Healthy Options Program in categories that are important for evaluation by state and local officials, including pregnant women, parents of young children, and children with special health care needs;

- Appropriate questions that can be expected to generate client responses reflecting their personal experiences with the health plans;
- Questions written or asked in the client's native language; and
- An implementation plan that provides clients with assistance in completion of the survey form.

This survey should be conducted annually and should be included in the overall monitoring tool as a point-in-time evaluation of client satisfaction. Because baseline information does not currently exist for the clients who have been enrolled into the Healthy Options program, much of the information for a baseline will need to be established from the first survey. Given the likelihood of start-up problems with a large program such as Healthy Options, the responses should be expected to reflect progress over time in solving initial problems and show a considerable reduction in negative responses.

For each of the population categories noted earlier, the client survey should focus on indicators that reflect clients' access to necessary services and their satisfaction with the services provided. These indicators are included in the tables that follow.

a. Perinatal Services

While early entry into prenatal care is measured through a variety of indicators, the ability of the client to obtain appointments in a timely manner is a critical factor in the receipt of the appropriate number of prenatal visits. In addition, a client's satisfaction with the services provided will affect her willingness to keep appointments. Finally, because the provider of medical services is not necessarily the provider of support services, the public health system will depend on the health plans to provide the necessary referrals for such services as Maternity Support Services and WIC Program services. Table 3-5 describes these three perinatal indicators and their utility.

Table III-5 Perinatal Survey Items			
Indicator	*Source of Data*	*Type of Indicator*	*Measure*
Ability to Obtain Prenatal Care Appointments Easily	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Timely Access to Necessary Services
Satisfaction With Prenatal Care Services	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Quality of Care
Receipt of Referral Information to Other Key Services	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Access to Necessary Services

b. Child and Adolescent Services

Public health programs emphasize the importance of preventive care for children. Referrals to the EPSDT program are a critical component of the public health department's function. Because families in the past have not been likely to seek preventive services, it is critical that these services be readily available to the client when they do seek them. Table 3-6 describes four child and adolescent health indicators that can be monitored through the client satisfaction survey.

Table III-6 Child and Adolescent Survey Items			
Indicator	*Source of Data*	*Type of Indicator*	*Measure*
Ability to Obtain Primary Care Appointments in a Timely Manner	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Timely Access to Necessary Services
Ability to Obtain EPSDT Appointments in a Timely Manner	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Timely Access to Necessary Services
Satisfaction With the Quality of Services	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Quality of Care
Receipt of Referral Information to Other Key Services	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Access to Necessary Services

c. Children With Special Health Care Needs

Because families of children with special health care needs will depend on the health system both to provide quality care to their children and to provide them with family support services, it is important that the health plans enrolling these children have a system in place to link with support services that are provided outside of the plan. In addition, it is important for these children to have an ongoing source of primary care. The only reliable source of information on how well the health plans will accomplish this task is a client survey. Table 3-7 shows the items to be addressed in this survey.

Table III-7 Children With Special Health Care Needs Survey Items			
Indicator	*Source of Data*	*Type of Indicator*	*Measure*
Ability to Obtain Specialty Care Appointments in a Timely Manner	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Timely Access to Necessary Services
Ability to Obtain Primary Care Appointments in a Timely Manner	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Timely Access to Necessary Services
Receipt of Appropriate Referrals to Case Management and Family Support Services	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Access to Necessary Services
Satisfaction With the Quality of Care Being Provided	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Quality of Care

d. Population as a Whole

Finally, Table 3-8 shows the client satisfaction information to be gathered through a survey of the general population enrolled in Healthy Options. Once a baseline for client satisfaction is established, the future surveys will be able to provide information on whether or not the health plans are improving on these key indicators.

Table III-8 Population-Wide Survey Items			
Indicator	*Source of Data*	*Type of Indicator*	*Measure*
Ability to Access Primary Care Services in a Timely Manner	Client Survey	Point-in-Time First Year to Establish Baseline; Trend Analysis Annually	Access to Necessary Services
Overall Satisfaction with Services Provided	Client Survey	Point-In-Time First Year to Establish Baseline; Trend Analysis Annually	Quality of Care

3. Key Informants Survey

In order to monitor the Healthy Options program from a system-wide perspective, it is important to collect information from those key individuals who work in programs or agencies that provide support services to the client population. The main purpose of a key informants survey is to provide additional information to state and local program managers about the MCH population's access to services, including services provided by the health plans and services that would normally be provided by agencies outside the plan. Quite often, this group of key informants can provide valuable observations regarding the types of problems clients experience with managed care plans. In addition, the key informants can present observations information about how well the managed care system is integrated with systems of support services that provide services to clients beyond traditional medical care.

The baseline section of this report contains results from a key informants survey conducted prior to the implementation of Healthy Options. As the nature of the service delivery system changes, there must also be a change in the people identified as "key informants." In order to have an accurate picture of the new system's impact on clients, new key informants will replace some of the ones who provided insights into the old system. At a minimum, the group of key informants that the survey should be sent to must include those who can provide complementary information to support key

indicators already mentioned in this report. It is critical that the key informants include those who have daily contact with low-income clients. This group would include:

- A representative sampling of local WIC program staff;
- Local Maternity Support Services and Maternity Case Management providers;
- Staff working in Early Intervention Programs funded by the state Birth To Six Program;
- Head Start and ECEAP Program staff;
- Family Support Services providers funded by the Children with Special Health Care Needs Program;
- MCH 800 hotline workers who refer clients to services;
- Representatives from Children's Hospital who provide case management and treatment services to children with special health care needs;
- Public health nurses providing home visiting services; and
- School-based clinic staff and others who provide services to adolescents.

State and local public health officials may wish to identify others to include in this survey, especially as the health delivery system begins to change and existing programs take on new importance.

3. Plan-Specific Reporting

Plan-specific information will not only provide insight into the performance of the individual health plans, but will also allow state and local officials to determine if problems within a specific plan are endemic to the system as a whole. Each of the health plans will be required to report specific client contact information to the state Medicaid agency so that it can monitor the quality of care provided to the Healthy Options clients.

Two critical indicators in the Medicaid reporting system will be initiation of prenatal care and immunization status of children. In addition, other information will be collected, including client complaints about services, chart reviews, and independent plan evaluations. The inclusion of plan-

specific information collected by Medicaid in the monitoring tool will be of great value in completing the picture of the service delivery system's impact on mothers and children.

This plan-specific information can be used to compare each plan's performance against many of the population-based indicators. Indicators that Medicaid uses to measure statewide impact on clients will be required reporting elements in the health plan contracts. These include some of the population-based indicators mentioned earlier in this report.

Additional indicators can also be gathered through the health plans, both for the population as a whole and for children with special health care needs. These indicators will need to have baseline data established once the plans begin to report. A list of specific indicators that could be measured using the health plan data are shown in Table 3-9.

Table III-9
Plan-Specific Indicators

Indicator	*Source of Data*	*Population Group*	*Measure*
Initiation of Prenatal Care	Required Health Plan Reporting	Perinatal	Access to Necessary Services and Quality of Care
Number of Emergency Room Deliveries	Health Plan Client Encounter Data	Perinatal	Access to Necessary Services
Immunization Status of Children	Required Health Plan Reporting	Children	Quality of Care
Service Use By Client Groups; In-Patient, Out-Patient, and Non-Hospital	Health Plan Client Encounter Data	Entire Population	Access to Care and Cost of Services
Number and Types of Specialist Providers in Health Plan	Health Plan Resources Listing	Children With Special Health Care Needs	Quality of Care and Access to Necessary Services
Number of Out-Of-Plan Specialist Referrals	Health Plan Data	Children With Special Health Care Needs	Access to Necessary Services
Number of Primary Care Visits	Health Plan Client Encounter Data	Children With Special Health Care Needs	Access to Necessary Services

5. Children With Special Health Care Needs

Additional sources of information are necessary for measuring managed care's impact on children with special health care needs. In addition to the above sources of information, the following sources will provide valuable information on these children's health status.

a. Physician Surveys

One of the major concerns expressed by state officials and local program staff is whether children with special health care needs will receive appropriate services in a managed care setting. Of major concern is the issue of the primary care physician "gatekeeper" who will control access to specialist care. In addition, regulations regarding the plans' arrangements with physicians and programs that currently serve these children are vague. The Children With Special Health Care Needs Program currently keeps a record of participating physicians who are providing care to enrolled children. It would be appropriate for the CSHCN program to conduct an annual survey of its providers to determine if they continue to be able to provide care to the clients they are seeing now, if they perceive any barriers to specialist care, and what recommendations they might make to improve access to specialty services. For the first year, the survey should focus on the following questions:

- Have physicians serving CHSCN continued to see the clients they were serving prior to the implementation of managed care?
- What formal relationships, if any, have been developed between the physician and the health plans? Do they formally participate in managed care plans? If so, do they participate only in a limited number of plans, or have they developed relationships with a majority or all of the plans? Do they participate as primary care doctors, or as specialty referrals only?
- Have arrangements for reimbursement between the health plans and the physicians affected the delivery of services to children with special health care needs?
- What issues, if any, arise from the "gatekeeper" role of the primary care physician in regard to the number or types of visits children receive from the specialist.

In subsequent years, the continuing relationship between the health plans and specialty physicians should be explored, particularly if the health plans develop new systems for

providing specialty care to children with special health care needs. Some physicians who currently provide services to these children have expressed concern that the health plans may try to develop "self-contained" systems for specialty care that will focus on cost-containment rather than quality, thereby further limiting access to care.

b. Case Studies

Often the best method of determining if special needs children are receiving appropriate services is to conduct case studies of families who depend on this system to provide appropriate care and referrals. Building off the information contained in the Baseline Data Set, case studies can be used to determine if a sample of families are receiving appropriate services, to identify issues of concern, and to assist plans and other programs in providing the best available services to these families. In selecting families for such case studies, the following criteria should be used:

- The families should include children with a variety of disabilities, in order determine if children with different disabilities have different experiences with the system;
- The families should participate in a variety of health plans; and
- The families should have older children who have dealt with the system for a number of years as well as younger children whose disabilities may have been recently diagnosed.

The information needed to select families for the case studies is available through the Children With Special Health Care Needs program. Information from the physician survey and the plan-specific data may also be used in choosing families for study.

D. Implementation of the Monitoring System

1. Introduction

The implementation of the monitoring system will require a coordinated effort by several staff members. Implementation will require collecting and analyzing data, preparing and distributing

surveys, preparing reports that describe and analyze survey information, coordinating with the Medicaid program to obtain plan-specific data, selecting families to include in case studies, and conducting the case studies. The end product of this effort will be an annual report on the health status of the women and children being served in the Healthy Options program. Prior to the actual step-by-step implementation of the monitoring tool, several planning activities must be undertaken. These are outlined below.

a. Establish a Coordinated Timeline

In order to carry out the activities necessary to implement the monitoring tool, a coordinated timeline will be necessary. This will involve identifying key dates when data will become available and setting specific goals for the collection, analysis, and publication of data. To develop the timeline, state and local MCH officials should coordinate with the Medicaid program and the state Center for Health Statistics to determine when data will be available. In addition, planning for the final design of the survey questionnaires and distribution dates should be timed to coincide with the availability of the other data. Families will need to be selected for the case studies and a schedule developed to collect information from the families. Finally, time must be set aside for the analysis of information, preparation of draft reports, review of the material by state and local officials, and preparation of the final report.

b. Identify Key Resources

Collecting all of the information needed for the report, analyzing the data, conducting the surveys, and completing the case studies will require a significant expenditure of staff time. The process will resemble, on a smaller scale, the one used to develop the MCH annual report. A method must be established to identify key staff and resources for this effort, and the roles and responsibilities of these staff must be defined.

The types of staff, at a minimum, that should be included in this effort are as follows:

- Those who are familiar with the collection and use of data for evaluation purposes;

- Those who can develop and administer surveys; and
- Program management staff who can use the data to develop program and policy recommendations.

This monitoring tool will also require a coordinated effort between local and state level staff. The current Steering Committee for this project could be an excellent vehicle for dividing tasks, defining roles and responsibilities, and coordinating the large number of activities that must take place.

c. Design a Final Report Format

The final product of this tool should be an annual report that will comprise several sections, including:

- A population-based data section that uses data obtained from a variety of sources to describe the overall status of the client population in terms of access to and quality of care;
- A descriptive section, based on the results of surveys conducted with clients and key constituency groups, that describes the clients', providers', and policymakers' satisfaction with the new system;
- A plan-specific section that compares outcomes from the individual plans with baseline data for the population as a whole and with standards established by the Public Health Improvement Plan;
- A case study section examining the specific needs and problems of children with special health care needs and their families; and
- A section that integrates the data collected in each category into a broader analysis of the Healthy Options' service delivery system and provides recommendations for public health interventions or program policy changes to adapt public health services to the new environment.

Basic steps for implementating various components of the monitoring system are discussed below.

2. Population-Based Data

Once staffing, resources, and a timeline have been established, state and local officials can begin the process of using the monitoring tool. Table 3-10 provides a sample format for displaying information the Population-Based Data portion of the monitoring report. This format can be used by those who collect the data to display the information in summary form. State and local officials will need to select either a database or a spreadsheet software package in which to input the summary data once it is obtained; the sample display chart will provide a guide for formatting this software. Because multiple factors could influence the outcome of each indicator, the collection and display of the data will need to portray a "big picture" view of the managed care system's impact on the client population. All of the indicators should be analyzed together in order to isolate the effects of managed care from those of other factors that may influence the health status of the population.

Table III-10
Sample of Population-Based Data

Perinatal Indicators	*Type of Indicator*	*Availability*	*Source of Data*	*Baseline Data*	*Current Data*
Percent of LBW Deliveries	Trend Analysis	Annually	First Steps Data Base	7.8%	NA
Number of Prenatal Slots Available	Trend Analysis	Monthly	King County OB Referral Program and SKCHD	6211	NA
Percentage of Clients Entering Prenatal Care In:	Trend Analysis	Annually			
First Trimester			First Steps Data Base	49.4%	NA
Second Trimester				23.6%	NA
Third Trimester				8.6%	NA
Missing				17.1%	NA
None				1.3%	NA
Percent of Eligible Women Receiving MSS/MCM Services	Trend Analysis	Quarterly	Maternity Support Services Reporting System	7475	NA
Number of Emergency Room Deliveries	Trend Analysis	Annually	Medicaid Client Visit Reporting	To Be Developed	NA
Number of First Steps Providers:	Trend Analysis	Quarterly			
MCM			First Steps Reporting System	34	NA
MSS				30	NA
Childbirth Education				13	NA

3. Surveys

As discussed above, much of the descriptive information about quality of services in the new managed care system will come from surveys. These surveys should present questions that are relevant to specific indicators and should include both open-ended and multiple-choice questions on each issue. The two types of responses should be analyzed separately.

Because the results of the surveys will present descriptive information, an appropriate sample size must be decided on for each survey. The key informant survey should be sent to the entire population of possible candidates, with an expectation that most will be returned. Physician surveys may also be sent to the entire population of candidates, with the expectation that not all of the survey forms will be returned. The client survey should be directed to specific sub-groups of the client population, with the expectation that many will not return the survey. The extent of follow-up on these surveys will depend on both the response rate and the level of effort needed to conduct follow-up.

Both the key informant and the physician surveys have specific target groups that state and local officials can identify from existing information. Because state and local MCH officials cannot send surveys directly to clients through the Medicaid program or the health plans, those selected for the client survey will need to be chosen with the cooperation of programs that see clients outside of the managed care setting. Programs currently run by SKCDPH are in the best position to contact clients to receive the survey. Because some clients will be eligible for, but not enrolled in, the Healthy Options program, using these population groups will also provide information on the effectiveness of the health plans' outreach efforts.

The analysis of this information will include the development of a descriptive report of the survey results, indicating the range of responses and the types of comments received. This report will provide a general picture of how satisfied the client population and other constituent groups are with the service delivery system.

4. Plan-Specific Information

As discussed, most of the information relating directly to the plans can be acquired through the Medicaid program or the plans themselves. Once this information is obtained, it can be displayed in a format to allow for comparison of each plan with either a uniform standard or with the baseline information for the population as a whole. This information can provide state and local officials with information on whether a specific plan is experiencing a particular problem, whether all or most of the plans are not meeting expectations, or whether the progress of a majority of the plans masks specific problems within a single plan.

Tables 3-11 and 3-12 show two sample formats for displaying the plan-specific data. The first sample format allows program managers to examine the performance of the health plan over a variety of indicators. The second sample table allows for comparison of all health plans by a specific indicator. Both will be valuable methods of displaying information and comparing the performance of the plans.

Table III-11
Individual Plan Performance By Indicator:
Sample Display Format for Plan-Specific Data
Healthy Plan A

Indicator	*Population Group Affected*	*Standard*	*Baseline*	*Plan-Specific Data*
Percentage of Women seeking Prenatal Care in First Trimester	Perinatal	90%	49.4%	X
Percentage of Children Fully Immunized by Age Two	Children	95%	54.3%	X
Service Use by Clients: Inpatient Outpatient Non-Hospital	Population as a Whole	NA	 1228 3.7% 2770 8.5% 28,474 87.8%	 X X X
Number of Out-Of-Plan Specialist Referrals	Children With Special Health Care Needs	NA	NA	X

Table III-12 Sample Cross-Plan Data Health Plan Performance by Indicator: Immunization Status of Children at Age Two Standard: 95% Baseline For Total Population: 54.3%		
Health Plan Name	*Baseline for Plan*	*Current Data*
CareNet	Not Yet Established	X
Community Health Plan of Washington	Not Yet Established	X
Ethix Health Plan	Not Yet Established	X
Group Health Cooperative of Puget Sound	Not Yet Established	X
King County Medical Blue Shield	Not Yet Established	X
Providence Health Plan	Not Yet Established	X
Pacific Health Plan	Not Yet Established	X

5. Case Studies of Families of Children With Special Health Care Needs

This section of the report will concentrate solely on children with special health care needs. Because little data are available on this population, and because the needs of families and children vary so widely, it is important that case studies be developed to examine how the transition to managed care is affecting these clients' access to services. The case studies should focus on those areas of access critical to the receipt of appropriate medical services and the availability of support services. These case studies should be conducted using an interview protocol that will collect specific, consistent information on the nature and severity of children's disabilities, the demographics of families, and the types of services needed and used by families. Specific problems families are experiencing, including access to care, appropriateness of referrals, and appropriate case management, should be discussed as well. The studies should be conducted by staff who are trained in interview techniques and the needs of families with special needs children and who can establish a rapport with the families in order to ensure that the information collected is accurate.

While this section will describe only a small number of families, the issues and concerns reflected in the studies will be helpful to program managers as they examine policy options for the Children With Special Health Care Needs program.

6. Summary and Recommendations

After the information collection stage has been completed during any given monitoring cycle, senior state and local MCH staff will need to integrate all of the information collected and develop a set of conclusions and recommendations. It will be important for program managers, the steering committee and others that may use this report to be presented with options regarding public health responses to address issues raised in the report. It is assumed that a report of this nature will be widely distributed and will also be of value to the Medicaid program as well as the health plans themselves.

E. Conclusion

Integrating all the information collected with this monitoring tool will provide state and local officials with a comprehensive picture of how well women and children are being served in managed care settings. By analyzing trends, comparing the status of clients to established standards, and comparing the results of survey and case study information with health status indicators, the monitoring system should allow MCH officials in Washington State to draw specific conclusions about the managed care system's impact on the maternal and child population.

The collection of information from a number of sources will provide a variety of perspectives on the system, and regular updates of the baseline data, as well as the addition of new indicators as data become available, will help to make this tool relevant to a changing health care system. This monitoring system should provide a starting point as state and local officials, as well as providers and families, face the challenges of the transition to managed care.

Appendix A: Key Informants and Pre-Implementation Survey

Key Informants Interviewed

Dennis Braddock
Director, Community Health Plan of Washington
August 16

Bill Hobson
Executive Director, Central Seattle Community Health Centers
August 17

Janet Varon
Evergreen Legal Services
August 18

Karen Brosowich
Advocate, Head Start Parent Policy Council Coordinator,
Seattle-King County Department of Public Health
August 31

Thiv Ing
Translator (Chinese, Cambodian)
September 1

Linh Tran
Translator (Vietnamese, Chinese)
Community Clinic Language Bank
September 3

Nancy Meltzer
Advocate, ARC, of King County
September 3

Amy Howarth
Manager, Community Health Council of King County
September 3

Joni Strong
Children with Special Health Care Needs Coordinator
Seattle-King County Department of Public Health
September 7

Susan Paeth
Clinical Nurse Specialist, Children's Hospital and Medical Center
September 8

Jan Sherman
Nurse Practitioner, Garfield/Nova Teen Health Center
September 9

Janice Rabkin
Coordinator, University of Washington First Steps Evaluation
September 9

Shirley Hutchinson
WIC Coordinator, Seattle-King County Department of Public Health
September 13

Allena Barnes
Advocate, Head Start Parent Policy Council
September 15

Ken Feldman, MD
Medical Director, Odessa Brown Clinic
September 15

Vinnie Hobson
Social Worker, Eastside CSO
September 17

Jowhara Shabazz
Social Worker, Rainier CSO
September 21

Mary Cunningham
Health Coordinator, Neighborhood House
September 23

Kate Willy
Family Resource Coordinator, Seattle-King County Department of Public Health
September 24

Elizabeth Nucci
Manager, Hospital Council OB referral line
September 24

Brad Roter, MD
Physician, Country Doctor Community Clinic
September 30

Evergreen Hospital Administrator
Associate Administrator, Evergreen Hospital
September 30

Colin Romero, MD
Medical Director, Puget Sound Neighborhood Health Centers
September 30

Frederick Connell, MD
Director, University of Washington First Steps Evaluation
September 30

Pre-Implementation Key Informant Survey

1. Do you think Medicaid recipients in the fee-for-service system receive adequate information about their health care coverage?

   If no, please describe what additional information should be provided.

2. To your knowledge, are problems, complaints, or grievances resolved in a satisfactory and timely manner for Medicaid recipients in the fee-for-service system?

   If no, please explain how the system could work better.

3. To your knowledge, do Medicaid recipients in the fee-for-service system receive care from the primary care physician of their choice?

   If no, please explain why and what needs to be changed to ensure enrollees are sufficiently able to do so.

4. Do you think that children have adequate *access* to well-child care under the Medicaid fee-for-service system?

   If no, please describe in what areas access is inadequate.

5. Do you think that children receive adequate *quality* of well-child care under the Medicaid fee-for-service system?

   If no, please describe what additional care should be provided.

6. Do you think children with special medical needs receive adequate care under the Medicaid fee-for-service system?

   If no, please describe what additional care should be provided.

7. Do you think adults with special or chronic medical needs receive adequate care under the Medicaid fee-for-service system?

   If no, please describe what additional care should be provided.

8. To your knowledge, do Medicaid recipients in the fee-for-service system receive medically necessary specialty care in a timely manner?

   If no, please explain why and what needs to be changed to ensure enrollees do receive needed specialty care.

9. To your knowledge, do Medicaid recipients in the fee-for-service system receive medically necessary inpatient hospital care?

   If no, please explain why and what needs to be changed to ensure enrollees do receive needed inpatient care.

10. To your knowledge, do Medicaid recipients in the fee-for-service system receive medically necessary emergency room care?

    If no, please explain why and what needs to be changed to ensure enrollees do receive needed emergency room care.

11. What elements of the community health care system in King County do you consider to be the most important for Medicaid-eligible people (e.g., community clinics, hospitals, WIC, private physicians)?

12. What elements of public health department services do you consider important to Medicaid-eligible families (e.g., immunizations, EPSDT, WIC, home visits, nutrition services, prenatal services, TB, STD, HIV/AIDS)?

13. In October, families on AFDC in King County will experience a change in their health care system. They will shift from fee-for-service care to managed care plans. Compared with fee-for-service Medicaid, do you think managed care will result in:

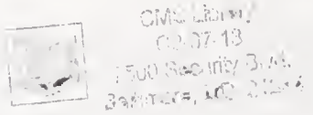
    Access that is better, worse, or about the same?

    Quality that is better, worse, or about the same?

    Health status that is better, worse, or about the same?

14. In your opinion, how will the community health care system in King County be affected by the Medicaid managed care initiative?

15. What issues or concerns should policy makers and program managers watch closely during Medicaid's transition to managed care in King County?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